Implementation of Medicaid Work Requirements:

Key Design Considerations and Strategies to Minimize Avoidable Coverage Loss

Adrianna McIntyre, Paula Giraldo, Ari Ne'eman, and Benjamin D. Sommers

Department of Health Policy & Management
Harvard T.H. Chan School of Public Health

Date: July 16, 2026

This work was supported by a research grant from Arnold Ventures.

EXECUTIVE SUMMARY

Beginning in 2027, states are required to implement work requirements for Medicaid expansion populations. Beneficiaries must meet an 80-hour per month requirement, engaging in work or other qualifying activities (such as community service, schooling, or a work training program), or qualify for an exemption (such as for medical frailty or pregnancy). Without verifiably meeting this requirement, new applicants will have applications denied and existing beneficiaries attempting to renew their coverage will be removed from the program.

Drawing on research from previous Medicaid work requirements, the unwinding of the pandemic continuous coverage provision in Medicaid, experience with work requirements and enrollment outreach in other programs such as the Supplemental Nutrition Assistance Program (SNAP) and ACA Marketplaces, this report synthesizes evidence and policy options available to minimize avoidable coverage losses during implementation of the new requirements.

Three steps in the implementation workflow will determine coverage outcomes:

A. First, will states have adequate information to automate a person's application or renewal without requiring additional documentation to be submitted by the enrollee?

    a. ***Key Finding:*** Research shows that *ex parte* verification – when states use data sources without placing an additional burden on applicants – is the most effective means of maintaining coverage among eligible individuals.

    b. ***Key Overall Recommendation:*** Data integration efforts between Medicaid enrollment, SNAP, public and private wage databases, and claims data are critical to qualifying or exempting as many eligible individuals as possible without requiring beneficiaries to navigate additional red tape.

B. Second, for those who cannot be automatically qualified or exempted, will they be able to navigate the eligibility system to obtain or maintain their coverage?

    a. ***Key Finding:*** Research shows that awareness of work requirements and the complexities of Medicaid rules is often low. Many beneficiaries may be unsure whether the requirements apply to them or what they need to do to qualify.

    b. ***Key Overall Recommendation:*** Multimodal outreach efforts, use of the national Change of Address database and other reliable sources to improve accuracy of contact information, and trusted messengers in both media campaigns and direct application assistance can help improve enrollment rates, but more intense efforts come at substantial cost.

C. Third, for current enrollees or potential new applicants who are not currently exempt or engaged in qualifying activities, what additional supports could help them meet the

requirements to obtain or maintain coverage?

a. ***Key Finding:*** Work supports in public programs have modest effectiveness, but only a small share of current Medicaid beneficiaries does not already meet the criteria (or an exemption) for coverage under work requirements.

b. ***Key Overall Recommendation:*** Due to the low number of potential beneficiaries, high cost, and limited effectiveness, states should prioritize *ex parte* approaches and outreach efforts to maintain coverage, rather than extensive work support programs.

I. Brief Overview of OBBBA Work Requirements and Purpose of This Report

Beginning in 2027, all states that expanded Medicaid under the Affordable Care Act (ACA), and some states that have expanded the program more modestly, will be required to implement mandatory work requirements for the Medicaid expansion population. This federal statutory mandate was enacted as part of H.R. 1, also known as the One Big Beautiful Bill Act (OBBBA). This marks the first time work requirements have been mandatory in the Medicaid program, though several states previously implemented (or started to implement) work requirements on an optional basis using 1115 waivers. While they are relatively new to Medicaid, work requirements have long been statutory obligations in other safety-net programs, including the Supplemental Nutrition Assistance Program (SNAP, previously known as food stamps) and Temporary Assistance to Needy Families (TANF).

Under OBBBA, Medicaid enrollees eligible for the program under ACA expansion must either have documented engagement for at least 80 hours per month in "qualifying activities" (working, job training, volunteering, enrollment in an educational program) or meet one or more specified exemptions. Exemptions include medical frailty and certain types of caregiving, among other criteria. States are expected to rely on available administrative data to automate qualifications and exemptions where possible, similar to how states use data to conduct Medicaid eligibility redeterminations on an automated ("ex parte") basis.

OBBBA also increases the frequency with which states must undertake full Medicaid eligibility redeterminations for the expansion population. Prior to its enactment, states could not conduct redeterminations more frequently than once every 12 months. Under the new law, states must conduct eligibility redeterminations for the expansion group at least once every six months. States can also conduct periodic data checks and choose to review compliance with work requirements in between renewals and act on observed changes.

On June 1, 2026, CMS released an interim final rule (IFR), establishing a federal framework to guide states' implementation activities.[1] Under the IFR, states generally have broad latitude to rely on attestation (also called auditable self-declaration) for most qualifying activities and exemptions in the first year. However, beginning in 2028, states' ability to rely on attestations is considerably more limited. One of the most notable departures from stakeholder expectations

was a narrowing of the medical frailty exemption.[2] In the IFR, CMS stipulates that a given diagnosis or medical condition does not, alone, provide evidence of frailty; states must demonstrate that the condition impairs an individual's ability to meet community engagement requirements. The new medical frailty definition, in addition to several other IFR provisions, is currently the subject of ongoing litigation.[3]

States retain some flexibility in how they implement work requirements. States can choose to verify work requirement compliance for one to three months preceding a non-exempt enrollee's application. Likewise, they may adopt different standards for assessing ongoing compliance: states can require that enrollees demonstrate engagement in qualifying activities in a single month, or at the other extreme, requiring compliance in each of the six months between redeterminations.

Together, these changes have raised significant concern among policymakers and stakeholders about potential coverage losses among individuals who remain eligible for Medicaid but cannot be determined in compliance or exempt based on administrative data and fail to meet reporting requirements. CBO estimates 5.3 million people will lose Medicaid and become uninsured in 2034 as a result of these provisions, with some analysts estimating higher losses.

The objective of this report is to examine the research and policy evidence on the effects of work requirements in Medicaid and other related programs and identify best practices that may reduce the risk of avoidable coverage losses during the implementation of the OBBBA's new Medicaid work requirements.

II. Approach & Source Material for Literature Review

We conducted a review of peer-reviewed journal articles and the grey literature — including think-tank analyses, government reports, and state-funded evaluations — on implementation challenges posed by Medicaid work requirements and potential best practices to overcome these challenges.

We examined formal and informal research on Medicaid work requirement as our primary focus. Given limited experience to date with work requirements in the program, we also included relevant information from the "unwinding" of Medicaid continuous coverage (which presented similar issues around enrollee outreach and eligibility determinations, though it affected all enrollees, not just the expansion population), enrollment outreach in the ACA Marketplaces, and work requirements in SNAP. Under federal law, SNAP imposes work requirements for certain "able-bodied adults without dependents" (ABAWDs), which are structurally similar, but not identical, to upcoming Medicaid work requirements.

Accordingly, in our review, we placed the greatest emphasis on evidence from Medicaid work requirements, secondarily on SNAP and Marketplaces, and the least emphasis on other safety

net programs (including TANF), due to these programmatic differences potentially reducing applicability of those findings.

We used the following keyword searches in PubMed and Google Scholar, and we expanded our list of keywords and new sources based on preliminary findings:

- Medicaid work requirements
- Medicaid unwinding
- Medicaid ex parte
- Medicaid outreach
- Medicaid take-up
- SNAP work requirements
- SNAP outreach
- SNAP employment and training
- TANF work supports
- Marketplace outreach
- Marketplace take-up.

We also identified grey literature and non-academic reports using Google, reference lists from other papers and reports, and website searches of key agencies (e.g. Centers for Medicare & Medicaid Services [CMS], Congressional Budget Office, and Congressional Research Service), foundations and think-tanks (e.g. KFF, State Health & Value Strategies, Commonwealth Fund, Urban Institute, and AcademyHealth), and other stakeholder organizations.

We synthesized key empirical findings across the categories of implementation considerations described above and at each stage attempt to characterize the strength of evidence for potential strategies to reduce adverse outcomes.

Finally, where relevant, we supplement empirical findings with feedback from state policymakers; these comments are summarized without attributions to specific individuals, agencies, or states in order to preserve confidentiality and encourage candid input.

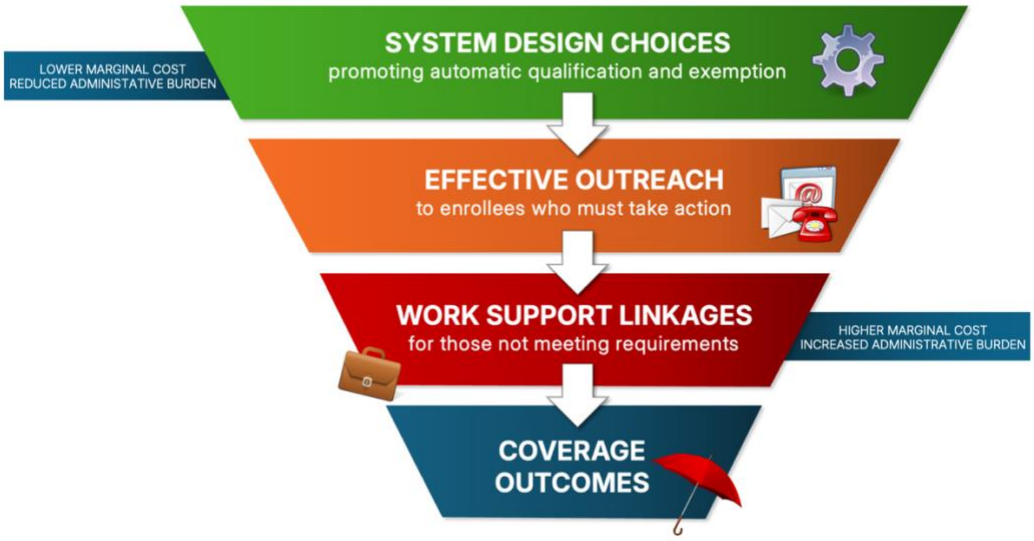
Our results are organized below into the following topic areas and themes:

A. System design choices to promote automatic qualification or exemption
B. Effective outreach to those who cannot be automatically qualified or exempted
C. Connecting people who are not exempt or engaged in qualifying activities to additional supports that could help them retain coverage

This approach follows the workflow that states will need to observe while implementing work requirements (**Figure 1**). System design choices will initially determine how many enrollees are automatically qualified or exempted from work requirements based on administrative data which states may vary in their ability to effectively use. Outreach will be necessary for cases that cannot be adjudicated automatically; *effective* outreach will minimize the number of eligible enrollees who fail to take action to maintain coverage. Finally, among people who are not exempt from or in compliance with work requirements, the state can act to connect individuals to work or other community engagement supports.

The report concludes with a summary of key recommendations.

Figure 1. Work Requirements Implementation Workflow and Coverage Outcomes



III. Key Findings of Evidence Review

A. System design choices to promote automatic qualification/exemption

The design and operation of eligibility and enrollment systems will be central to how Medicaid work requirements function in practice. OBBBA requires states to use administrative data where possible to automate qualification and exemption processes, and a wide range of research studies offer strong evidence that automation is substantially better than outreach and "nudges" at promoting benefit take-up and retention. In two states that implemented (Arkansas) or nearly implemented (New Hampshire) work requirements, half to two-thirds of enrollees subject to the requirements were automatically qualified or exempted, but a majority of the remainder were disenrolled or would have been disenrolled if the state had not suspended the work requirement policy.[4] In Michigan, over 80,000 "Healthy Michigan Plan" enrollees — or about one in seven people receiving coverage under Medicaid expansion — were slated to lose coverage because of a work requirements policy, despite most still being eligible. In response, this policy was invalidated by a federal court before terminations took effect. This suggests that disenrollment under the OBBBA could lead to much higher coverage losses, including other unintended consequences like coverage losses for children, if some states are not able to match Arkansas and New Hampshire's relatively high rates of automatic qualification and exemption.

However, state Medicaid IT systems vary considerably in their operation and integration across programs.[5] This state-level variation will likely lead to uneven enrollment outcomes as states implement Medicaid work requirements. There are steps states can take to improve their systems and streamline processes, though these changes — often requiring lengthy procurements and validation exercises — may require a longer time horizon that is possible for the initial year of OBBBA work requirement implementation in 2027.

States may also encounter difficulties drawing lessons about system design from experience with other public programs in this context. SNAP programs cannot fully automate the process of deeming someone qualified (in compliance) because beneficiaries still must undergo periodic recertification interviews; even though states may use administrative data sources to verify information attested during these interviews, the interviews themselves preclude full automation of their renewal.[6]

> **KEY TAKEAWAY:** Automation of applications, exemptions, and renewals should be a priority for states, since this is the most effective means of maintaining coverage in the face of state efforts to implement Medicaid work requirements to date.

A1. Lessons from Medicaid "Unwinding"

State experiences during the "unwinding" of Medicaid continuous coverage after the COVID-19 pandemic offer some useful insights. Beginning in March 2020, all states accepted additional federal support for their Medicaid programs made available in the Families First Coronavirus Response Act. This funding was conditioned upon a "continuous coverage" requirement; states generally could not remove enrollees who experienced a change in eligibility while continuous coverage was in effect. The requirement ended March 31, 2023, and states spent the next year or more conducting eligibility redeterminations for their full Medicaid populations.[7]

During this "unwinding" of continuous coverage, states were required to report detailed redetermination outcome data for the first time; efforts to examine similar data prior to the pandemic found that only 13 states reported data of suitable quality for analysis.[8] By the time the process concluded, 25 million people had been disenrolled from Medicaid. Most of those — about seven in 10 — were disenrolled for "procedural" reasons, meaning that the state had been unable to ascertain their eligibility status due to incomplete verification materials, a lack of sophisticated systems with access to a range of data, or no renewal application at all. Procedural terminations are concerning because they reflect, in part, some people who lose Medicaid coverage despite likely remaining eligible. This relates to the concern that some or even most people are expected to lose coverage under work requirements while in compliance with the policy — or because they are otherwise exempt — because they fail to meet reporting requirements.

Research on unwinding renewal outcomes found that states with more coverage-promoting policies had lower rates of procedural terminations and disenrollment.[9] Evidence from a late-2023 survey of low-income adults in four states suggested that nearly half of low-income adults exiting Medicaid became uninsured.[10] Other studies reported higher disenrollment rates among individuals with mental health conditions, with mixed findings on racial and ethnic disparities in coverage loss; there is also some evidence that legal immigrant enrollees may have fared

worse than citizen enrollees, which may, in part, reflect language barriers in renewing coverage.[11–15]

In the first 12 months of unwinding, the number of Medicaid redeterminations that ended in termination as a share of March 2023 enrollment (the last month of continuous coverage) varied more than six-fold: Maine had terminated only 8.3% of people that had been enrolled as of March 2023 while Oklahoma terminated more than 50%.[16] New application rates increased more in states with high procedural termination rates, suggesting that these higher rates reflected more termination of eligible enrollees who were unable to meet renewal paperwork requirements.

All states took at least one action toward improving ex parte renewal rates in the lead-up to unwinding, according to a survey of state officials.[17] A majority of states adopted federal waiver flexibilities initially made available on a temporary basis during unwinding; the availability of some of these waivers was later made permanent.[18] Most states also reported improving system rules (N = 39); others reported expanding the number of data sources used (N = 22), changing data source hierarchy (N = 12), or revising limits on the age of data that could be used (N = 9).

During the unwinding process, several states participated in an intervention coordinated by the Centers for Medicare and Medicaid Services (CMS) and the United States Digital Service (USDS) to help states improve their ex parte renewal rates by offering technical assistance (helping states more effectively apply existing rules and data sources) and expanding states' technical capacity.[19] Intervention states experienced significant increases in ex parte renewal rates (21.6 percentage points), increased overall renewals (7.7 percentage points), and decreased procedural denials (8.3 percentage points) compared to non-intervention states.

Some strategies that states identified as particularly useful during unwinding are limited in their generalizability to the work requirements context. For example, states reported that "income strategy" waivers (which permitted the use of older income data in some cases where new data were not available) were instrumental in promoting higher ex parte renewal rates; three-quarters of states adopted at least one of these strategies.[17,20,21] However, states are unlikely to be permitted to rely on older data for purposes of work requirement qualification, given the constraints of the statutory language. Furthermore, some of the new activities or criteria relevant for work requirement eligibility — such as student status or caring for a disabled family member — were historically not components related to Medicaid eligibility and therefore not part of the unwinding process.

SPECIFIC RECOMMENDATION:

Recommendation: Implement permanently-extended 1902(e)(14) waivers that are likely to improve retention among eligible Medicaid enrollees subject to the work requirements, including the MCO Renewal Support Strategy, SNAP income verification strategies, and the Presumptive Eligibility (PE) Strategy where applicable.

A2. Potential gains from system integrations and expanded data sources

As evidenced by the unwinding experience, states seeking to maximize automation of work requirement exemptions and qualifications stand to benefit from expanding the universe of administrative data they use. This may require a combination of better integration of existing data sources (e.g., better linkages of data within the Medicaid program, and coordinated data exchange between state programs) plus the addition of new data sources.

One important factor that presents challenges to states seeking to do so is that state eligibility and enrollment systems ("E&E") and Medicaid claims data based on utilization are typically separate systems, operated by separate vendors. This, plus the time lag of claims adjudication, stands to complicate efforts to use claims data to automatically exempt people on the basis of clinical data (such as diagnosis codes that could be used to identify medical frailty, or utilization codes to indicate treatment for substance use disorder). In conversation with state stakeholders, it was apparent that claims lag varied both across states and across service types. In general, pharmacy and inpatient claims were expected to be adjudicated and available to states more quickly than outpatient claims (including claims related to behavioral health services). While pharmacy lags were sometimes just days or weeks, the shortest lags for visits were often on the order of about 3 months, while services with longer lags could take six months to a year (or more) to be fully adjudicated and available in state systems, depending on the state. States may seek to rely on Medicaid Managed Care Organizations (MCOs), which may have encounter or claims data available more quickly.

For new applicants with no prior history in the Medicaid program, states may also explore the utility of data available from state health information exchanges (HIEs), all-payer claims databases (APCDs) and similar entities.[22] Several themes related to HIEs arose in conversations with state stakeholders. Individuals generally agreed that HIEs could offer valuable information to support ex parte determinations of medical frailty or as data sources to verify attestations in cases where attestation alone is not sufficient. However, the technological and logistical challenge of integrating clinical HIE data into the Medicaid eligibility determination process is formidable, particularly for states that do not have prior HIE-Medicaid linkages; bridging these systems will be, in some cases, a multi-year project.

In 2027, the first year of implementation, states will generally have broad latitude to rely on attestations (also called auditable self-declarations) for medical frailty and other exemptions; attestations will also be permitted for medical frailty on a more limited basis starting in 2028.[1] Considerations related to attestations are described in section A3 (system factors to consider when ex parte exemption/qualification is not feasible).

In addition to identifying medically-frail enrollees, claims data can help states identify and exempt pregnant enrollees who may have enrolled in the program through a separate eligibility pathway. One recent study showed that only 56% of pregnant Medicaid enrollees are enrolled via the "pregnancy pathway" at the time of delivery, meaning states may not always be aware of

who is pregnant.[23] Among states that had expanded Medicaid as of 2018 and had available data, 13% of pregnant enrollees on average were in the Medicaid expansion eligibility category; in six states (IL, KY, MT, NJ, VT, WA) more than 20% were in the expansion group. This might occur when, for example, someone becomes pregnant after enrolling in Medicaid by meeting expansion eligibility criteria.

Strategies that rely on linkages to state SNAP eligibility systems may offer some promise. As of early 2025, 17 states were or were planning to use federal waiver flexibilities to use SNAP gross income determinations to support Medicaid enrollment and renewals.[24] In SNAP, enrollees must recertify every six or twelve months, depending on eligibility category and state policy; in states using longer certification periods, to maintain their coverage beneficiaries must still submit six month "interim reports," which include questions about income changes.[25] Because these more frequent requirements have been longstanding in SNAP — and because lapsed SNAP benefits may be more salient than Medicaid disenrollment, particularly for healthier enrollees — people concurrently enrolled in both programs may be more responsive to requests for information from the SNAP program.

Tighter integration between Medicaid and SNAP eligibility systems could also streamline states' ability to identify Medicaid applicants and enrollees who are exempt from Medicaid work requirements because they are already subject to SNAP work requirements. The Congressional Research Service estimates that this group could represent about one-third of people expected to be subject to the new Medicaid work requirements.[26] At present, only about half (N = 26) of states report integration between their MAGI Medicaid and SNAP eligibility systems.[24] In the absence of full integration, states could work with eligibility system vendors to develop reliable processes for extracting SNAP participation data on a regular basis to support adjudication of work requirement compliance or exemptions. Research has found, however, that SNAP work requirements drive disenrollment — including among people who likely remain eligible for the program — with one study suggesting that few people re-enter SNAP after benefit termination even when work requirements aren't enforced, which could inhibit the efficacy of this strategy for enrollees over time.[27–32]

There are several internal and external data sources that states can leverage to automatically qualify people based on meeting the monthly work hour (80 hours per month) or wage (80 × federal minimum wage per month) criteria. Quarterly wage data submitted to the state by employers may be reliable and already integrated into state Medicaid eligibility systems. However, quarterly wage data generally only includes "W-2" workers, but excludes self-employed individuals, including those in the gig economy.

In addition, lags in data availability will inhibit the utility of these wage data, particularly for new applicants who, if not exempt, need to demonstrate compliance in the month prior to application. For example, consider an applicant who must take action to renew coverage by the end of June 2027. Most states initiate ex parte renewals 60 or more days prior to the coverage period ending, meaning the state may be attempting an eligibility determination in mid- or late April.[17]

Depending on the speed with which wage data are submitted and processed, information for 2027Q1 (January-March) may not be available to state Medicaid agencies by this time.

Third-party data sources, including those that rely on payroll data (e.g., Equifax's "The Work Number") or bank statement application programming interfaces (APIs) can offer more timely data, though gaps still persist.[33] A 2016 GAO report found that The Work Number covered 35-40% of the working population at any given time, and the share among low-income workers might be lower.[34] Ongoing costs related to third-party data sources — which may be as much as $15 per query — are also a concern for states, given limited implementation funding.[35,36]

A more recent innovation is "consent-based verification" (CBV), where enrollees permit a third-party technology to access data from payroll or financial institutions.[33,35,37] Take-up may prove challenging; a program piloting a similar opt-in technology in Louisiana reported a 7% response rate.[38] States might consider identifying and partnering with major financial institutions and gig employers in their state to improve take-up rates in advance of work requirement implementation. CMS is piloting a CBV data sharing tool known as Eligibility Made Easy, or "Emmy," that states will be able to use, though its reach and effectiveness remain to be seen.[39,40] The agency is also developing an application programming interface (the Emmy API) that will allow states to directly connect to resources like the National Student Clearinghouse and the Veteran Affairs API, though its utility cannot be known prior to implementation.

In prior qualitative work related to ex parte renewals in the context of Medicaid unwinding, key stakeholders noted that technical limitations were often not the primary challenge for system integration. Instead, restrictions on available resources, internal capacity, and available time to implement changes operated as more binding constraints.[41] Another source of variation and uncertainty was the hierarchy in which data sources should be applied for the most efficient adjudication of a case.[33,35,41]

These dynamics are likely to persist, as the enabling legislation only allocated $200 million to states for implementation (HR1); as a comparison, Georgia spent over $50 million on implementation of its work requirements.[42] While states can receive 90/10 federal match[a] on new funds spent on some aspects of system updates, even paying for 10% of the costs may prove prohibitive for states in a context where overall federal Medicaid spending is slated to decline and state options for raising revenue via provider taxes will be limited.[43]

One concern that may arise for states pursuing maximizing ex parte rates is whether the process of shifting to more automated processes could inadvertently lead to renewal of people who have become ineligible for the program or otherwise worsen Payment Error Rate Measurement (PERM) Program error rates, which may create audit liability for states. Starting October 2029 (FY 2030), states are subject to mandatory penalties for eligibility errors (erroneous spending above 3% of total spending).

[a] Federal financial participation differs by category of administrative spending: 90% for the design, development, installation, or enhancement of eligibility and enrollment (E&E) systems; 75% for the operation and maintenance of those systems; and 50% for all other costs required to administer the Medicaid program properly.

To minimize liability under this provision, states will consider approaches to reduce eligibility errors including those related to work requirements. States should consider opportunities to conduct periodic internal audits prior to enforcement to ensure that new methods of community engagement adjudication do not create unintended program integrity concerns. Best practices for these internal checks should be widely disseminated across states.

States' decisions about data sources, data hierarchies, and other implementation considerations, create opportunities for cross-state lessons. A convening or research organization should collect information from states on design choices that can foster cross-state learning and strengthen future evaluation efforts.

While states are expected to report application and renewal outcomes for the population newly subject to work requirements to CMS, the metrics required only distinguish between those deemed in compliance and those deemed excluded/exempt.[44,45] These will offer little insight into the extent to which states rely on manual versus ex parte determinations of exemption and compliance, limiting the ability to draw cross-state lessons from them.

SPECIFIC RECOMMENDATIONS:

Recommendation: Align policy implementation decisions (e.g., in how many months an enrollee must have been working prior to renewal or application) where states have flexibility; where data have significant lags or missingness, more lenient discretionary policies may be appropriate.

Recommendation: Improve data integration across existing state systems (Medicaid MMIS, SNAP, wage, unemployment insurance, and other relevant databases) and explore new sources of information to maximize the extent to which states can automatically qualify or exempt enrollees (third-party vendors, HIEs, APCDs, MCOs, National Student Clearinghouse). Consider identifying and partnering with major financial institutions and gig employers to improve take-up of consent-based verification technologies in advance of work requirement implementation.

Recommendation: Continuously evaluate and prioritize which data sources produce the largest gains in successful automatic renewals and accurate qualification/exemption decisions.

Recommendation: Monitor and report application and renewal outcomes in a manner that fosters transparency and learning about best practices in the context of work requirements implementation. Consider reporting metrics distinguishing between procedural terminations for not meeting standard eligibility criteria versus not providing required information to substantiate community engagement and between determinations that relied on automated versus ex parte determinations.

A3. System factors to consider when ex parte exemption/qualification is not feasible

When ex parte exemption or qualification is not feasible, existing Medicaid beneficiaries as well as would-be applicants will need to navigate the new work reporting requirements. This raises important questions about how such data will be collected by states.

All states currently offer an online application portal option, in addition to applications by mail, fax, or in-person. However, lower-income Americans are more likely to rely on smartphones as their primary internet source. According to Pew Research Center, one-third (34%) of adults with household incomes below $30,000 reported being smartphone-reliant.[46] Despite this fact, as of January 2025, only 13 of 49 states surveyed offered a mobile app through which Medicaid enrollees could submit documentation for purposes of verifying eligibility.[24] Apps also have other potential advantages over online portals, even those that are mobile friendly, such as the ability to "push" notifications and reminders to enrollees who need to take action to maintain their coverage.

The new work requirements will require additional data to be collected compared to pre-OBBBA Medicaid policies. In particular, screeners for medical frailty and other exemptions at the time of application or renewal will be needed, as states may not have access to administrative data on new applicants who have had prior limited experience with state programs or those who have only been enrolled for a short period of time (or who only recently developed conditions that might qualify them as medically frail).[47] Evidence suggests that minimally-burdensome approaches to such screeners would be more effective than any approach requiring additional up-front documentation or action.[48,49]

While the policy details underlying work requirements are complex, states must endeavor to keep application language simplified and accessible, including by providing examples where appropriate (e.g., describing example conditions that would meet medical frailty requirements). Prior work in SNAP found that simplifying language and adding examples increased the number of people who correctly identified themselves as self-employed; without the clarifying language, people working "gig" jobs were less likely to correctly identify themselves as such.[50]

To the extent feasible, medical frailty and other screeners should be embedded within the application or renewal form, rather than constituting an additional form that must be completed and returned separately. Added administrative steps — even small ones — can lead to errors and incomplete documentation. For example, an intervention to streamline enrollment in the Massachusetts Health Connector – using a check-the-box enrollment form – increased enrollment, but only for those enrollees who qualified for and selected plans that were $0 after subsidy. While many people who owed premiums returned the form, very few followed up with premium payments to effectuate coverage.[49]

In conversations with state stakeholders, attestations were expected to occupy a central role (particularly in the case of medical frailty determinations) in the first year due to inadequate time to implement ex parte processes. These conversations also highlighted concerns about PERM

audits related to allowable attestations. Perhaps counterintuitively, PERM audit risk *increases* when states require documentation beyond that minimally required by statute and regulation (e.g., specific diagnoses for attestations of medical frailty, which enrollees may not know the accurate clinical terms for), as each documentation requirement introduces new opportunities for errors by enrollees, case workers, and state technology systems.

Finally, in addition to the policy environment and data infrastructure in each state, state administrative capacity will also be an underappreciated but potentially important driver of enrollment outcomes. For instance, will states be able to recruit and retain workers with experience and skills in enrollment and eligibility issues? This was identified as a "top concern in most states" during the unwinding period, according to a report from CMS, and likely will continue to be a challenge in the OBBBA era.[51] In 2023, the average Medicaid agency vacancy rate was 17 percent, although it was as high as 30 to 40 percent in some states.[52] Additionally, Medicaid staff will need to be trained on new policies, and the more frequent eligibility redeterminations under OBBBA (every 6 months for expansion groups instead of 12 months) will also lead to increased workload. Limitations based on state workforce capacity were recently cited in litigation over terminations of coverage from Florida Medicaid, for instance; the following quote from one state employee in the Department of Children and Families Call Center exemplifies some of the challenges that may lie ahead: "We're not able, based on our capacity… to answer as many calls as we would like to be able to answer."[53]

SPECIFIC RECOMMENDATIONS:

Recommendation: Where ex parte qualification or exemption is not possible, adopt exemption screeners at application that minimize reporting burden to the extent feasible while meeting federal auditable self-declaration requirements.

Recommendation: Expand use of Medicaid mobile apps (or websites with app-like functionality) for reporting and documentation, including use of push notifications.

Recommendation: In implementing self-attestations, use plain language providing examples (where appropriate) and enforce only those documentation obligations necessary to meet statutory and regulatory requirements. Embed attestations/screeners seamlessly within existing application frameworks.

Recommendation: Anticipate and address administrative capacity constraints by investing in staffing, training, and call center infrastructure. Periodically evaluate strategies to improve recruitment, training, and retention of essential eligibility personnel.

B. Effective outreach to those who cannot be automatically qualified or exempted

Awareness of Medicaid work requirements, particularly in the first few years, is likely to be a key challenge. Existing beneficiaries who cannot be automatically qualified or exempted will not

know to comply with requirements of which they are unaware. Furthermore, would-be applicants who are confused by work requirements may be discouraged from applying in the first place, even though they may in fact be eligible.

A survey conducted in Arkansas shortly after the state implemented work requirements in 2018 found that one-third (33%) of enrollees likely subject to them had heard "nothing at all" about the requirements and an even greater share (44%) were unsure whether the new policy applied to them.[54] Focus groups in Arkansas documented similar levels of confusion.[55] Poor awareness and understanding of Medicaid policies was also documented during the post-pandemic unwinding, with surveys conducted at different times finding that between 30% and 62% of enrollees had heard nothing at all about the resumption of Medicaid eligibility redeterminations (with some variation attributable to different survey timing).[56–58] Many Medicaid beneficiaries may not know whether their enrollment is based on expansion eligibility or not, which is the primary determinant for whether they are subject to work requirements.

Furthermore, this situation may be confounded by enrollee confusion about whether they are enrolled in Medicaid at all. The gap between Medicaid enrollment according to state enrollment files and the self-reported share of the population with Medicaid (often called the Medicaid survey "undercount") has grown in recent years; it accelerated while the continuous coverage provision was in effect during the pandemic and began to narrow during unwinding.[16,59–61] Some research suggests that the rise of Medicaid managed care, with Medicaid enrollees experiencing coverage in ways that feel similar to commercial insurance, may contribute to the undercount; alternative program names may also create confusion.[62] Needless to say, if a person is unaware that their coverage is in fact provided by Medicaid, they are unlikely to take proactive steps to satisfy new Medicaid-related eligibility rules such as work requirements or apply for an exemption.

In considering outreach strategies and lessons from past experience state stakeholders highlighted a key distinction from Medicaid unwinding: that only a subset of enrollees — generally those who qualify via Medicaid expansion, with a few small exceptions — are subject to work requirements. Among those who are technically subject to the policy, the state may be able to automatically exempt or qualify enrollees based on existing data. Thus, it may be the case that adults in households with multiple Medicaid-enrolled adults will face different obligations under the policy, exacerbating confusion.

KEY TAKEAWAYS: Effectively raising awareness and implementing communication strategies that promotes enrollee responsiveness to agency requests for information will be essential for minimizing avoidable coverage losses. Outreach should be conducted to all enrollees, including those who do *not* need to take action related to the new requirements.

B1. Ensuring complete and accurate contact information

As a first-order matter in outreach, states must work to ensure complete and accurate contact information. States are required by law to conduct periodic outreach to Medicaid enrollees subject to work requirements. The legislation requires that notices be delivered by postal mail (unless an enrollee has elected to receive notices electronically) and by at least one additional means (telephone, text message, email, or internet portal, for example). A similar multimodal outreach requirement was in place during Medicaid unwinding, but surveys suggest that people were much more likely to be made aware of the need to take action to renew by postal mail (about 90% of enrollees) than by alternative means.[57,58]

It is not entirely clear what to make of these findings: mail may be more effective than other modalities; it may simply be more frequently used than other modalities; or other modes of outreach may be used to nudge people to check their mail, rather than providing detailed information. Concerns emerge about telephone-based outreach because people are less likely to answer calls from unrecognized numbers, though one nationally-representative survey found that low-income adults are more likely (24%) to report answering such calls than middle- (18%) or upper-income (14%) respondents, and large majorities reported checking voicemails from declined calls.[63]

Outreach to the Medicaid population is complicated by the fact that low-income individuals are more likely than higher-income individuals to experience housing insecurity and other forms of residential instability. An analysis of Census data found that one in ten Medicaid enrollees moved at some point in 2020.[64] Under new flexibilities granted to states during unwinding, Medicaid agencies could use the U.S. Postal Service's (USPS) National Change of Address (NCOA) database to update contact information (without first receiving consent from the enrollee), but only 27 states report currently using this option.[24] One survey found that, among low-income people who reported moving during the pandemic, a large majority (70%) updated their address with the USPS.[58] While OBBBA delayed implementation of CMS's *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* Final Rule until 2035 it does require states to collect updated information from NCOA, returned mail with in-state forwarding, and from MCOs. But unlike CMS's E&E rule, states are not required to accept this information without further verification.[65]

Telephone numbers also suffer from instability and inaccuracies. One study in Wisconsin found that, among Medicaid enrollees who could not be renewed automatically, only about half (53%) of telephone numbers were judged by a third-party commercial vendor to be correct, with the remainder split between being judged incorrect (23%) or having uncertain accuracy (24%).[66] The accuracy of alternative contact information from these vendors may require additional validation before states can determine whether the associated costs (estimated at about $1 per person, based on prior research) are a worthwhile expense.[67]

Managed care organizations may have more routine contact with enrollees than state agencies because of their more primary role in administering health benefits (and, in some cases, coordinating care). As such, they should be considered valuable partners in educating enrollees about the new work requirements and potential sources of more up-to-date contact information. States might consider incorporating renewal support activity as a quality measure in MCO contracts (with attendant financial incentives, as appropriate).

SPECIFIC RECOMMENDATION:

Recommendation: Move expeditiously to integrate the USPS National Change of Address database for updating contact information for beneficiaries who may have moved. Ensure that data exchanges between states and MCOs enable a timely exchange of reliable updated contact information. Explore suitability of data from commercial third-party data vendors for enhancing available contact information.

B2. Efficacy of outreach to individual applicants

Research evidence on the effect of individual-level outreach to boost program enrollment is mixed and varies across study settings, particularly as it relates to the relative advantage of "high touch" (information plus assistance) over low-touch (information only) interventions. This distinction is crucial, as high-touch interventions are much more resource-intensive.

Findings in the Medicaid context have been inconsistent, likely reflecting the range of interventions and populations that have been studied.

Prior to ACA implementation, Oregon partially expanded their Medicaid program using a lottery (known as the Oregon Health Insurance Experiment). In 2013, a randomized subset of lottery participants received additional outreach beyond the standard notification letter and application.[67] The low-intensity intervention group received additional postcards, postal mailings, e-mails, and pre-recorded telephone outreach, plus address tracking and updates from USPS, at an estimated cost of $1.75 per person; notably, this intervention would be considered "high intensity" in other contexts (including more recent Marketplace-based research). In the Oregon study, the (very) high-intensity outreach group received the same reminders, plus personalized telephone and in-person outreach and enrollment assistance, at an estimated cost of $28 per person. While the low-intensity intervention increased take-up meaningfully (41 percent compared to 27 percent among the control group), the high-intensity intervention group only had take-up 0.5 percentage points higher than the low-intensity group.

A more recent experiment in Wisconsin randomized Medicaid enrollees who could not be renewed automatically during the unwinding process to receive a pre-recorded telephone call that provided information about their renewal deadline and information about a no-cost hotline they could call to receive enrollment assistance from a navigator.[66] This intervention only modestly increased renewals by 1 percentage point (from 68% to 69%), with larger effects observed for tribal members, people with chronic diseases, and people with incomes below the

sample median. Calls sent in the afternoon (1pm) were significantly more effective than those sent in the evening (7pm). However, the study authors estimate that, at best, only 61% of outbound calls were likely received, due to incorrect numbers, full voicemail boxes, and other issues.

Some states have delegated key state outreach and enrollment activities to designated independent "enrollment brokers." However, an examination of enrollment outcomes after states newly contracted with these vendors between 2008 and 2018 did not find any significant effect on Medicaid take-up rates or other enrollment outcomes (e.g., improved application processing times) when compared to states that never contracted with enrollment brokers.[68]

Texting as a tool to promote Medicaid take-up or retention is particularly understudied, likely because of legal concerns that limited states' use of texting prior to unwinding.[69] A technical assistance document for states indicates that weekday afternoon text messages have higher click rates than texts sent at other times, consistent with the Wisconsin telephone experiment.[66,70] One study, which used a text-based intervention to try to increase insurance coverage (including but not limited to Medicaid) among self-pay patients discharged from the emergency department found marginally significant evidence that the intervention increased enrollment.[71] Text-based interventions intended to better connect Medicaid patients to clinical care generally have not yielded significant results.[72–74]

In the SNAP context, one RCT found that outreach, including text messages, was modestly (but significantly) more effective at promoting successful recertification than standard written communications and automatic telephone outreach alone (62 percent compared to 59 percent).[75]

Despite findings ranging from null to modest, it remains possible that texting is an important outreach mechanism, given focus groups suggesting that Medicaid enrollees favor multimodal outreach, including text messaging, and the relatively low cost of texts.[76]

There is a larger and more consistent literature on different types of outreach on take-up of Marketplace coverage, many evaluating randomized controlled trials. In general, this research finds that mail- and telephone-based outreach can have a statistically significant effect that is meaningful on a relative basis, but the absolute increases in take-up or retention are often quite modest, on the order of one to five percentage points.[49,77–84] Counter to the Oregon Medicaid study described above, simple reminders were significantly less effective than outreach interventions that focused on reducing the hassle costs of enrollment processes (that is, provided some form of assistance beyond passively providing information), with one meta-analysis estimating that interventions offering enrollment support were about three times more effective than information-only interventions.[85]

Several studies suggest that interventions offering information and assistance may have particularly pronounced effects for Hispanic enrollees or those preferring Spanish-language communications.[71,79] Paired with findings elsewhere that Hispanic enrollees are at higher risk of

losing coverage at renewal, this research may suggest that enrollees that plausibly face language barriers may be effective targets for more intensive interventions, when resources are scarce.[86]

American Indian and Alaska Native (AIAN) individuals may also benefit from such interventions. OBBBA technically exempts tribal members from work requirements, but some AIAN individuals may be inappropriately disenrolled or may not be aware they are exempt. One analysis by the National Council of Urban Indian Health estimated that over 850,000 AIAN individuals lost coverage during the post-pandemic unwinding; tribal health leaders and patient benefit coordinators indicated that tribal citizens did not receive their redetermination paperwork or struggled to fill it out and send it back to their state Medicaid agency.[87] Paperwork challenges may be exacerbated in these communities by delays in receiving and sending mail in rural areas, housing instability, and lack of street addresses and/or reliable internet service on remote reservations.

States may also consider targeting individuals at key junctures when they may be at heightened risk of losing Medicaid. For example, if someone loses their job and takes longer than a month to find new employment, their opportunity to enroll in Medicaid may lapse, leaving them without a job and without a path to health insurance. States may consider finding ways to nudge these individuals to enroll early (concurrently with unemployment insurance, for example).

A more intensive form of outreach is personalized enrollment assistance.[88] Previous studies have shown that third-party application assistance can be effective, though there have been few head-to-head comparisons with information-only outreach approaches. One study of the ACA Medicaid expansion found that receipt of application assistance was the strongest predictor of successful enrollment in coverage among low-income adults, and that Hispanic adults were the most likely to receive such assistance.[89,90] Another study showed that eligibility assistance at community health centers was associated with higher insurance enrollment compared to centers without such assistance, though these results did not translate to detectable state-level enrollment differences.[91]

Outreach activities are generally funded as administrative costs that receive a federal matching rate of 50%. In light of other changes to program financing, states may find it financially difficult to expand outreach activities, or even to sustain current levels of outreach. This suggests a need to test and scale effect outreach messages, to ensure efficient use of outreach dollars, and an important role for MCOs, health care providers and other community partners.

SPECIFIC RECOMMENDATIONS:

Recommendation: Identify and consider nudging enrollment at key junctures when people may newly become eligible for Medicaid and still have sufficient employment history to qualify for Medicaid (for example, immediately upon applying for unemployment insurance).

Recommendation: Consider embedding low-cost evaluations (e.g., A/B testing) in their outreach strategies to identify the messages that are most effective at nudging enrollees to action.

B3. Indirect and Targeted Outreach Through Media Campaigns and Trusted Messengers

Because individuals may require multiple touchpoints to fully understand coverage requirements and take action, media campaigns will play a critical role in outreach. **Table 1** summarizes some available evidence and known trends for different outreach trends.

Table 1.

Outreach channel	Key evidence and trends
Print media	Print advertising placed with trusted community partners offers high-traffic and high-trust venues for information dissemination. • Key venues include churches, beauty and barber shops, grocery stores, libraries, small businesses, job placement sites, schools, and sports leagues.[88] Print materials can be enhanced with interactive features, such as QR codes, that link users directly to websites or shareable digital content via mobile devices.
Broadcast television and streaming media	Higher volumes of ACA-era television advertising during open enrollment were associated with declines in uninsurance, driven primarily by Medicaid enrollment. • Uninsurance declined by an average of 0.1 percentage points per 1,000 advertisements, with larger effects for state-sponsored advertising[92] In 2023, nearly 40% of viewers reported watching television via streaming services.[93]
Radio, podcasts, and YouTube	While most Americans still listen to at least some radio weekly, audiences are increasingly shifting toward online radio platforms and podcasts.[94] Podcasts and niche radio stations (such as Spanish-language stations) offer opportunity for community targeting. According to Pew Research, about a quarter of all U.S. adults (26%) say they get their news from YouTube, with most naming it as an important way they stay informed.[94]
Social media	Social media enables both broad and targeted dissemination but requires content tailored to platform norms. • Both demographic and geographic targeting could be useful in educating enrollees about work requirements Social media campaigns should prioritize concise, adaptable content and strategic timing to maximize visibility and engagement across platforms. Black and Hispanic audiences use social media at a higher rate than their white counterparts.

Information provided by state governments has been judged more acceptable to the public than information coming from private insurers, suggesting that state agencies should not fully cede outreach to MCOs (though, as discussed elsewhere, MCOs are likely to be valuable partners).[95]

In states that rely on county agencies for program administration, there may be additional value in county-based outreach, as local government is slightly more trusted than state government.

Community based organizations (CBOs) are often advantaged as trusted messengers by virtue of shared identities and other dimensions of cultural competence.[96] During COVID-19, one study found that CBOs in the Philadelphia area ranked among friends and family, the internet, and primary care as likely sources of information about health and vaccines.[97] In addition to likely occupying a more trusted position, CBOs may have more frequent contact with enrollees than the state or MCOs. CBOs partnering with Medi-Cal's Health Navigator project found that it takes two to four "touches" to merely complete enrollment for one consumer, as this involves initial outreach to explain plan options and next steps.[98]

Finally, peer-to-peer models, which train community members like spiritual leaders, barbers, and community health workers/*promotores* to share information are an effective way to engage hard-to-reach demographics.[96] The Arthur Ashe Institute created a program that used barbershops to engage Black men in health education, demonstrating effectiveness in improving attitudes and self-efficacy around HIV-prevention activities and was associated with lower risky sexual behaviors and increased feelings of community empowerment. This model proved effective as well during the COVID-19 pandemic to distribute personal protective equipment and educate about vaccination.

SPECIFIC RECOMMENDATION:

Recommendation: Pursue outreach in partnership with trusted entities. States may consider giving MCOs more latitude to participate in outreach activities and leveraging community based-organizations, peer-to-peer models, and health care providers as trusted messengers. Where resources are limited, consider prioritizing organizations that are well-connected to communities that are likely to include enrollees at elevated risk of being disenrolled despite remaining eligible (Hispanic enrollees, for example). Key stakeholders should ensure parity in the content of communications drafted for English and non-English audiences.

B4. Leveraging Health Care Providers and Point-of-Care Interactions

Health care providers may be underutilized as partners in helping promote continuous coverage for eligible enrollees. Like MCOs, it is possible that health care providers have more recent or more complete contact information than state agencies, particularly for enrollees with ongoing health needs. People are also twice as likely to report trusting their own doctors for health information (86%) as state government officials (42%). Existing state models for this include Texas's "community partners" program, in which health care providers and other organizations providing health and social services can become certified to provide assistance with Medicaid paperwork and case management.

States with sufficient programmatic infrastructure might consider (1) leveraging claims data to identify primary care providers that have seen enrollees in the preceding year and (2) delivering these providers monthly lists of patients who are at risk of losing coverage if they do not take action to confirm their eligibility or community engagement. Direct outreach explicitly targeting those who could not be renewed on an ex parte basis occurred during the unwinding process, but it is not clear how frequently these outreach activities leveraged health care providers as trusted messengers. States may wish to explore innovative strategies for financing (or encouraging MCOs to finance) these outreach activities. They may also wish to explore strategies that permit providers to verify patients' medical exemptions where they cannot be adjudicated automatically.

In conversations with state stakeholders, some commented that providers have raised several liability concerns related to verifying medical frailty on behalf of patients, including references to both the False Claims Act and Anti-Kickback Statute. Additional guidance from state and federal policymakers on the permissibility of provider attestations would be useful. However, even if these attestations are deemed acceptable, states indicated that it could take considerable time and resources to develop systems for systematically accepting such records and incorporating them into their administrative systems for use in eligibility determinations.

The potential role of medical claims in automating medical frailty exemptions also raises the potential value of having states or medical professional organizations circulate best-practices guidelines on what diagnosis codes are relevant for such exemptions. For instance, if a qualifying condition is present but not relevant for billing purposes, clinicians should be educated to provide as much detail as possible to ensure that states are best able to make accurate, automatic determinations of medical frailty. States might also explore the feasibility of medical claims modifiers, such that clinicians can indicate directly that a condition interferes with an individual's ability to meet the new requirements.

Pharmacies are also an important potential touch-point for enrollees. During the unwinding process, a survey of low-income adults in four southern states found that people were most likely to find out about Medicaid coverage loss from official state communications. However, one in four learned about their coverage change while seeking care, and attempting to fill a prescription was the most common point of care where this occurred (in 11.8% of cases) followed by trying to make an appointment at a doctor's office (8.1%).[58]

SPECIFIC RECOMMENDATION:

Recommendation: Systematically leverage health care providers and pharmacies as trusted touchpoints for identifying and assisting enrollees at risk of losing coverage, including by sharing lists of patients who must take action to confirm eligibility or community engagement. Where feasible, explore ways for providers to support medical exemption determinations, including through clearer guidance qualifying diagnoses, best documentation practices, and permissible forms of provider-based attestation.

B5. Additional Evidence-Based Strategies for Targeting ESL/Immigrant Populations

Engaging populations who speak English as a second language (ESL) and immigrant communities may be more challenging in the foreseeable future because of ongoing immigration enforcement activities. These populations are already at elevated risk of being less informed about their coverage options and losing coverage at renewal.[86,95]

To mitigate work requirement and renewal coverage losses, prioritize making culturally and linguistically appropriate assistance available to immigrants by leveraging trusted messengers like CBOs, community health workers, and *promotores*. CBOs that may particularly be able to reach immigrant populations may include churches, schools, grocery stores, community centers, food banks, shopping centers, community health centers, homeless shelters, and immigrant support organizations.[98]

In trying to reach individuals who speak English as a second language (ESL), advertising via Spanish-language radio and newspapers was found particularly cost-effective.[88] However, ESL-targeted campaigns should attend to ad content to ensure that advertising is not missing key information. In 2018, Spanish-language health insurance ads contained significantly fewer mentions of insurance and marketplace options, with only 22% of all ads mentioning financial assistance opportunities, potentially leaving Spanish-speakers at an information disadvantage.[99] It is also important for states to use non-stigmatizing terminology (e.g., “non-citizen” instead of “immigrant”, “undocumented” instead of “illegal/unlawful”) in their messaging.[100]

SPECIFIC RECOMMENDATION:

Recommendation: Prioritize culturally and linguistically appropriate outreach to ESL and immigrant communities relying on trusted communicators (e.g., community health workers, schools, churches, food banks, immigrant-serving and other community-based organizations) and targeted channels (e.g., Spanish-language radio and newspapers).

C. Connecting people who are not exempt or engaged in qualifying activities to supports to enable coverage

Prior research on the Medicaid population indicates that most adults already meet requirement thresholds by working (or engaging in another qualified activity) for at least 80 hours a month, or else should qualify for an exemption. In a study of Arkansas’ 2018 work requirements, more than 95% of those subject to the rules already met the community engagement requirement or should have been exempt. Another national study found that just 0.3-5.6% of Medicaid-eligible individuals would be subject to but not meeting work requirements.[54,101]

Nonetheless, these statistics indicate that several hundred thousand people may need to increase their work or other community engagement hours in order to maintain Medicaid

coverage. There is limited evidence to date on work supports as a tool of increasing employment in the context of safety-net programs.

Somewhat paradoxically in the setting of the current policy, research suggests that having Medicaid itself is a strong enabler of employment opportunities, as evidenced in an Ohio Medicaid expansion evaluation that found that 75% of enrollees said having Medicaid made it easier for them to look for work, and another 52% said that having Medicaid made it easier for them to keep working.[102] Research using longitudinal administrative data has also found that income among low-income adults in expansion states increased an additional 9.5 percent in the five years following expansion compared to similar adults in non-expansion states.[103] However, given the structure of the OBBBA, giving people Medicaid first to facilitate employment subsequently is not an allowable approach for states.

KEY TAKEAWAYS: Most Medicaid enrollees are already working, should be exempt from, or otherwise appear to be in compliance with Medicaid work requirements. Prior workforce development initiatives have had only modest effects on labor force participation and earnings. More effective models likely require substantial up-front investment and increased administrative capacity.

As part of SNAP, states administer Employment & Training (E&T) programs, which are intended to assist enrollees with skill development, workforce training, and employment opportunities; SNAP agencies often partner with other state, local, and community-based organizations to provide these services. However, in 2016, there were only 200,000 E&T participants, a small fraction of the 6.1 million people enrolled in SNAP and subject to work requirements.[104] SNAP officials cited a variety of potential reasons for low take-up, including poor awareness, inadequate childcare, challenges with transportation (particularly among rural individuals), mental health needs or substance use issues, and challenges related to being formerly incarcerated.

A longitudinal randomized evaluation of 10 E&T programs from 2016 to 2019 yielded consistent increases in job search assistance or training activities, but mixed results on actual employment participation and earnings.[105] The pilots increased employment in the second and third years by four to six percentage points (from baseline rates of 7% to 22%, depending on the state), but only in five of the 10 states participating in the pilot programs. Statistically significant increases in earnings were only observed in three of the states.

Recent research in TANF found that a comprehensive work supports program increased employment by 10 percentage points (compared to a control mean of 44%) and increased earnings $861 per quarter (a relative increase of 48%) among participants in Colorado.[106] However, this program was highly resource-intensive. In addition to receiving job placement assistance, work experience opportunities, and supportive services (transportation and childcare), the state fully covered wages for job placements for up to six months, making it hard

to generalize to the typical context (including Medicaid) where employers would be responsible for paying workers directly and where workers often have higher incomes on average than among TANF recipients.

A meta-analysis of active labor market program evaluations found statistically significant but substantively small effects of such programs, on the order of one to three percentage points in the short run, with slightly larger medium-run effects.[107] However, these studies spanned a range of program types, demographics, and nations (only 12 of the 138 studies were from the U.S.).

Even if these programs are effective, a concern that arose in conversations with state-level stakeholders is that existing public workforce development programs have insufficient capacity to meet current demand. Introducing Medicaid work requirements without scaling support to these programs will exacerbate these issues.

SPECIFIC RECOMMENDATION:

Recommendation: Engage Medicaid enrollees prior to implementation to understand perceived needs to more effectively promote workforce development programs and labor force participation. Consider rigorously piloting different workforce development initiatives to better understand which initiatives are most likely to be effective.

IV. Conclusions & Summary of Recommendations

Based on the evidence reviewed in this report, the following recommendations can be synthesized from the various topics explored.

Policy Design

Recommendation: Align discretionary policy decisions (e.g., in how many months an enrollee must have been working prior to renewal) with the limitations of available data sources; where data have significant lags or missingness, more lenient discretionary policies may be appropriate.

Recommendation: Implement permanently-extended 1902(e)(14) waivers that are likely to improve retention among eligible Medicaid enrollees subject to the work requirements, including the MCO Renewal Support Strategy, SNAP Strategy, and PE Strategy where applicable.

Recommendation: Where ex parte qualification or exemption is not possible, adopt exemption screeners at application that minimize reporting burden to the extent feasible while meeting federal auditable self-declaration requirements.

Recommendation: Expand the use of Medicaid mobile apps (or websites with app-like functionality) for work reporting and eligibility documentation, including the use of push notifications.

Data, Systems, and Administrative Capacity

Recommendation: Improve data integration across existing state systems (Medicaid MMIS, SNAP, wage, unemployment insurance, and other relevant databases) and explore new sources of information to maximize the extent to which states can automatically qualify or exempt enrollees (third-party vendors, HIEs, APCDs, MCOs, National Student Clearinghouse). Develop validated approaches to exempting enrollees on the basis of medical frailty using claims data, relying on MCOs as necessary to ensure reliable and timely data. Consider identifying and partnering with major financial institutions and gig employers to improve take-up of consent-based verification technologies in advance of work requirement implementation.

Recommendation: Move expeditiously to integrate the USPS National Change of Address database for updating contact information for beneficiaries who may have moved since last contact; consider using data from MCOs and third-party data tracking vendors to enhance available contact information.

Recommendation: Anticipate and address administrative capacity constraints by investing in staffing, training, and call center infrastructure. States should periodically

evaluate strategies to improve recruitment, training, and retention of essential eligibility personnel.

Beneficiary Communications and Support

Recommendation: Pursue outreach in partnership with trusted entities. States may consider giving MCOs more latitude to participate in outreach activities (refer also Recommendation #1) and leveraging community based-organizations, peer-to-peer models, and health care providers as trusted messengers. Where resources are limited, consider prioritizing organizations that are well-connected to communities that are likely to include enrollees at elevated risk of being disenrolled despite remaining eligible (Hispanic enrollees, for example). Key stakeholders should ensure parity in the content of communications drafted for English and non-English audiences.

Recommendation: Identify and consider nudging enrollment at key junctures when people may newly become eligible for Medicaid and still have sufficient employment history to qualify for Medicaid (for example, immediately upon applying for unemployment insurance).

Recommendation: Engage Medicaid enrollees prior to implementation to understand perceived needs to more effectively promote workforce development and labor force participation. Consider rigorously piloting different workforce development initiatives to better understand which initiatives are most likely to be effective.

Transparency, Monitoring & Continuous Learning

Recommendation: Continuously evaluate which data sources produce the largest gains in successful automatic renewals and accurate qualification/exemption decisions.

Recommendation: Monitor and report application and renewal outcomes in a manner that fosters transparency and learning about best practices in the context of work requirements implementation. Consider reporting metrics distinguishing between procedural terminations for not meeting standard eligibility criteria versus not providing required information to substantiate community engagement and between determinations that relied on automated versus ex parte determinations. Similar to actions during the unwinding, states should consider creating dashboards on performance of 6-month Medicaid work requirement renewals to promote transparency and allow evaluation of how states and beneficiaries are faring.

Recommendation: Consider embedding low-cost evaluations (e.g., A/B testing) in their outreach strategies to identify the messages that are most effective at nudging enrollees to action.

Timeline for Recommendations

States are under tremendous time constraints to be ready for work requirements to go live by January 1, 2027, or even earlier in states that choose to do so. Our recommendations can be classified into two categories based on timeline – those priorities for initial (Year 1) implementation, and those that are longer term, either in terms of feasibility or likely effects. Our Year 1 recommendations prioritize those changes that were deemed most practical and/or important for the program's initial implementation. It is critical that states that are moving early on implementing work requirements adopt these recommendations as soon as possible.

Recommendations:	**Year 1 Priority**	**Longer-Term Priority**
1. Implement permanently-extended 1902(e)(14) waivers that are likely to improve retention among eligible Medicaid enrollees subject to the work requirements, including: MCO Renewal Support Strategy, SNAP Strategy, and PE Strategy.	X	X
2. Align discretionary policy decisions with the limitations of available data sources; apply more lenient discretionary policies in cases where data lags or is incomplete.	X	X
3. Improve data integration across existing state systems and explore data sources to automatically qualify or exempt enrollees more efficiently. Partner with financial institutions and gig employers to improve use of consent-based verification tools before work requirement implementation.	X	X
4. Continuously evaluate which data sources produce the largest gains in successful automatic renewals and accurate qualification/exemption decisions.	X	X
5. Report application and renewal outcomes to promote transparency and inform best practices for work requirement implementation. Amend current renewal metrics to report outcomes separately for the population subject to work requirements and distinguish between terminations due to ascertained noncompliance with community engagement requirements, inadequate information related to community engagement requirements, and inadequate information related to other eligibility criteria.	X	
6. Where ex parte qualification or exemption is not possible, adopt exemption screeners at application that minimize reporting burden.	X	
7. Expand use of Medicaid mobile apps/app-like functionality for work reporting and eligibility documentation.		X

8. Invest in staffing, training, and call center infrastructure. States should periodically evaluate strategies to improve recruitment, training, and retention of essential eligibility personnel.		X
9. Integrate the USPS National Change of Address database for updating contact information for beneficiaries; consider using data from MCOs and third-party data tracking vendors to supplement this effort.	X	
10. Nudge enrollment at key junctures when people may newly become eligible for Medicaid and still have sufficient employment history to qualify for Medicaid.		X
11. Embed low-cost evaluations in their outreach strategies to continuously evaluate efficacy to identify the effective messaging.	X	
12. Partner with trusted entities—including MCOs, community-based organizations, peer networks, and healthcare providers—to conduct outreach, prioritizing groups connected to communities at higher risk of erroneous disenrollment. Ensure parity in communications drafted for English and non-English audiences.	X	
13. Engage Medicaid enrollees to understand perceived needs vis-a-vis promoting labor force participation.		X

Finally, this report – much like implementation of Medicaid work requirements – will need to be a flexible and evolving document. Interviews with stakeholders and state officials will inform future versions of this report, to reflect the rapidly changing landscape of policymaking and program implementation in this space.

REFERENCES

1. Medicaid Program; Community Engagement Requirement for Certain Individuals. Federal Register. June 3, 2026. Accessed June 5, 2026. https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals

2. Bannow T, Cirruzzo C, Payne D. Trump's Medicaid work requirements have an unwelcome surprise for some states and patients. *STAT*. June 3, 2026. Accessed June 15, 2026. https://www.statnews.com/2026/06/03/medicaid-work-requirements-experts-say-millions-will-lose-coverage/

3. *Commonwealth of Massachusetts v. Oz*. (United States District Court for the District of Massachusetts). Accessed July 1, 2026. https://www.courtlistener.com/docket/73546826/commonwealth-of-massachusetts-v-oz/

4. Karpman M, Haley JM, Kenney GM. *Assessing Potential Coverage Losses among Medicaid Expansion Enrollees under a Federal Medicaid Work Requirement*. Urban Institute; 2025. Accessed January 22, 2026. https://www.urban.org/research/publication/assessing-potential-coverage-losses-among-medicaid-expansion-enrollees-under

5. Why did they do it that way? Eligibility policy. National Association of Medicaid Directors. November 13, 2023. Accessed January 22, 2026. https://medicaiddirectors.org/resource/why-did-they-do-it-that-way-eligibility-policy/

6. Rowe G, Gothro A, Brown E, Dragoset L, Eguchi M. *Assessment of the Contributions of an Interview to SNAP Eligibility and Benefit Determinations: Final Report*. United States Department of Agriculture, Food and Nutrition Service, Office of Policy Support; 2015. Accessed January 22, 2026. https://fns-prod.azureedge.us/sites/default/files/ops/SNAPInterview.pdf

7. Dague L, Ukert B. Pandemic-era changes to medicaid enrollment and funding: Implications for future policy and research. *Journal of Policy Analysis and Management*. Published online October 21, 2023. doi:10.1002/pam.22539

8. Schpero WL, Brahmbhatt D, Liu MX, Ndumele CD, Chatterjee P. Variation in Procedural Denials of Medicaid Eligibility Across States Before the COVID-19 Pandemic. *JAMA Health Forum*. 2023;4(11):e233892. doi:10.1001/jamahealthforum.2023.3892

9. McIntyre A, Aboulafia G, Sommers BD. Preliminary Data on "Unwinding" Continuous Medicaid Coverage. *New England Journal of Medicine*. 2023;389(24):2215-2217. doi:10.1056/NEJMp2311336

10. McIntyre A, Sommers BD, Aboulafia G, et al. Coverage and Access Changes During Medicaid Unwinding. *JAMA Health Forum*. 2024;5(6):e242193. doi:10.1001/jamahealthforum.2024.2193

11. Bensken WP, Koroukian SM, McGrath BM, Alberti PM, Cottrell EK, Sills MR. Unwinding of Continuous Medicaid Coverage Among Patients at Community Health Centers. *JAMA Health Forum*. 2024;5(1):e234622. doi:10.1001/jamahealthforum.2023.4622

12. Rumalla KC, Nelson DB, McConnell KJ, Zhu JM. Racial and Ethnic Disparities in Medicaid Disenrollment After the End of the COVID-19 Public Health Emergency. *JAMA Intern Med*. Published online June 3, 2024. doi:10.1001/jamainternmed.2024.1503

13. Marinacci LX, Mein SA, Engel-Rebitzer E, Figueroa JF, Wadhera RK. Medicaid Disenrollment by Race and Ethnicity in the United States: A National Cross-Sectional Analysis. *J GEN INTERN MED*. Published online September 11, 2024. doi:10.1007/s11606-024-08886-5

14. Barofsky J, Kao LS. *How Did Immigrants Fare During Medicaid Unwinding?* ideas42 Policy Lab; 2024. https://www.ideas42.org/wp-content/uploads/2024/08/I42-1506_PIFMedicaid_Report_final_Sept.pdf

15. Soni A, Blackburn J. Health Characteristics of Adults Unable to Complete Medicaid Renewal During the Unwinding Period. *JAMA Health Forum*. 2025;6(3):e250092. doi:10.1001/jamahealthforum.2025.0092

16. McIntyre A, Morein M, Kim J, Figueroa JF, Sommers BD. US Coverage Changes During Medicaid Unwinding in 2023. *JAMA Health Forum*. 2025;6(10):e253887. doi:10.1001/jamahealthforum.2025.3887

17. Brooks T, Tolbert J, Gardner A, Corallo B, Moreno S, Mudumala A. A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond. KFF. June 20, 2024. Accessed January 22, 2026. https://www.kff.org/medicaid/a-look-at-medicaid-and-chip-eligibility-enrollment-and-renewal-policies-during-the-unwinding-of-continuous-enrollment-and-beyond/

18. Boozang P, Serafi K, O'Connor K. CMS Releases Guidance on Optional Long-Term Use of Unwinding-Related Section 1902(e)(14) Waivers. November 15, 2024. Accessed January 22, 2026. https://shvs.org/cms-releases-guidance-on-optional-long-term-use-of-unwinding-related-section-1902e14-waivers/

19. Herd P, Giannella ER, Barofsky J, Farrell L, Moynihan D. Interventions To Automate Medicaid Renewals Reduce Procedural Denials And Increase Coverage: Article examines automated Medicaid renewals. *Health Affairs*. 2025;44(11):1336-1343. doi:10.1377/hlthaff.2025.00316

20. Haley JM, Allen EH, Brooks T, et al. *Improving Medicaid/CHIP Redeterminations for Children*. Urban Institute; 2024.

21. COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals. Medicaid.gov. May 1, 2024. Accessed May 2, 2024. https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html

22. Kahn J. The Potential of Health Data Utilities to Support Implementation of HR 1 Requirements for Medicaid. Consortium for State and Regional Interoperability. October 27, 2025. Accessed January 22, 2026. https://thecsri.org/news/blog/the-potential-of-health-data-utilities-to-support-implementation-of-hr-1-requirements-for-medicaid/

23. Gordon SH, Whitman A, Buchmueller T, Sommers BD. Medicaid Eligibility Category Among Enrollees With Medicaid-Paid Births in 2018. *Health Services Research*. 2026;61(1):e70053. doi:10.1111/1475-6773.70053

24. Brooks T, Tolbert J, Mudumala A, et al. Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations. KFF. April 1, 2025. Accessed January 22, 2026. https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/

25. Wagner J, Eppes E, Nchako C, et al. *Looking Across the Landscape: State Opportunities to Increase Access to SNAP, Medicaid, and WIC*. Center on Budget and Policy Priorities; 2025. Accessed January 22, 2026. https://www.cbpp.org/research/health/looking-across-the-landscape-state-opportunities-to-increase-access-to-snap

26. Aussenberg RA, Baumrucker EP, Falk G. *Work Requirements: Comparison of Medicaid and Supplemental Nutrition Assistance Program (SNAP) After P.L. 119-21*. Congressional Research Service; 2025.

27. Stacy B, Scherpf E, Jo Y. The Impact of SNAP Work Requirements. Published online December 14, 2018.

28. Gray C, Leive A, Prager E, Pukelis K, Zaki M. Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply. *American Economic Journal: Economic Policy*. 2023;15(1):306-341. doi:10.1257/pol.20200561

29. Cook JB, East CN. The Disenrollment and Labor Supply Effects of SNAP Work Requirements. *National Bureau of Economic Research*. Preprint posted online May 2024:32441. doi:10.3386/w32441

30. Ndumele CD, Factor H, Lavallee M, Lollo A Jr, Wallace J. Supplemental Nutrition Assistance Program Work Requirements and Safety-Net Program Participation. *JAMA Internal Medicine*. 2025;185(1):92-100. doi:10.1001/jamainternmed.2024.5932

31. Factor H, Wallace J, Lavallee M, Lollo A Jr, Ndumele CD. SNAP Work Requirements Reversal and Program Enrollment. *JAMA Health Forum*. 2025;6(5):e251587. doi:10.1001/jamahealthforum.2025.1587

32. Cook JB, Cox E, East CN. SNAP Work Requirements, Administrative Burden and Procedural Denials. *National Bureau of Economic Research*. Preprint posted online January 2026:34698. doi:10.3386/w34698

33. Serafi K, Sbrana L, Dervan L. Medicaid Work Reporting Requirements: Verifying Compliance and Exemptions. Published online November 5, 2025. Accessed January 22, 2026. https://shvs.org/wp-content/uploads/2025/11/SHVS_Work-Requirements-Compliance-and-Exemptions-Verification_11.5.25.pdf

34. *Supplemental Nutrition Assistance Program: More Information on Promising Practices Could Enhance States' Use of Data Matching for Eligibility*. Government Accountability Office; 2016. Accessed January 22, 2026. https://www.gao.gov/assets/690/680660.pdf

35. Wagner J, Singleton S, Stewart M. *A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid's New Work Requirement*. Center on Budget and Policy Priorities; 2025. Accessed January 22, 2026. https://www.cbpp.org/research/health/a-guide-to-reducing-coverage-losses-through-effective-implementation-of-medicaids

36. Kliff S, Sanger-Katz M, Elkeurti A. 'A Big Positive': How One Company Plans to Profit From Medicaid Cuts. *The New York Times*. November 3, 2025. Accessed January 22, 2026. https://www.nytimes.com/2025/11/03/health/medicaid-cuts-equifax-data.html

37. RFI - Consent-Based Income Verification Solutions. SAM.gov. December 11, 2023. Accessed January 22, 2026. https://sam.gov/opp/8a8030e1d5ba45709e213a959b77a7cf/view

38. Bichell RE, Whitehead S. Officials Show Little Proof That New Tech Will Help Medicaid Enrollees Meet Work Rules. KFF Health News. October 23, 2025. Accessed January 22, 2026. https://kffhealthnews.org/news/article/medicaid-eligibility-tool-pilot-test-work-requirements-ai-louisiana-arizona-georgia/

39. Singleton S. Understanding CMS's "Emmy" Medicaid Work Requirement Tools. Center on Budget and Policy Priorities. April 13, 2026. Accessed June 16, 2026. https://www.cbpp.org/blog/understanding-cmss-emmy-medicaid-work-requirement-tools

40. Eligibility made easy. Centers for Medicare & Medicaid Services. July 8, 2026. Accessed July 14, 2026. https://www.cms.gov/medicaid-chip/community-engagement-support/eligibility-made-easy

41. *Increasing the Rate of Ex Parte Renewals*. MACPAC; 2023. Accessed January 22, 2026. https://www.macpac.gov/wp-content/uploads/2023/09/Increasing-the-Rate-of-Ex-Parte-Renewals-Brief.pdf

42. *Medicaid Demonstrations: Information on Administrative Spending for Georgia Work Requirements*. Government Accountability Office; 2025. Accessed October 24, 2025. https://www.gao.gov/assets/gao-25-108160.pdf

43. Section 71119 of the "Working Families Tax Cut" Legislation, Public Law 119- 21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals (CMCS Informational Bulletin). Published online December 8, 2025. Accessed January 22, 2026. https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf

44. CMS-10398 #35: Eligibility and Enrollment Performance Indicators. Published online June 3, 2026. Accessed July 6, 2026. https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10398-35

45. CMS-10434 #66: Eligibility Processing Data Report and Renewal Compliance Template. Published online June 3, 2026. Accessed July 6, 2026. https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10434-66

46. Internet, Broadband Fact Sheet. Pew Research Center. November 20, 2025. Accessed January 4, 2026. https://www.pewresearch.org/internet/fact-sheet/internet-broadband/

47. *Designing Effective Verification Pathways for Exempt Populations at Heightened Risk of Coverage Loss Under Mandatory Work Reporting Requirements*. State Health & Value Strategies, Manatt; 2025. Accessed January 22, 2026. https://shvs.org/wp-content/uploads/2025/12/Verification-Pathways-for-Exempt-Populations-Toolkit_Final.pdf

48. Fox AM, Stazyk EC, Feng W. Administrative Easing: Rule Reduction and Medicaid Enrollment. *Public Administration Review*. 2020;80(1):104-117. doi:10.1111/puar.13131

49. Ericson KM, Layton TJ, McIntyre A, Sacarny A. Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment. *Review of Economics and Statistics*. Published online March 5, 2025:1-32. doi:10.1162/rest_a_01573

50. Moynihan D, Giannella E, Herd P, Sutherland J. Matching to Categories: Learning and Compliance Costs in Administrative Processes. *J Public Adm Res Theory*. 2022;32(4):750-764. doi:10.1093/jopart/muac002

51. Centers for Medicare & Medicaid Services. Medicaid and CHIP Unwinding Planning Efforts: Summary of Best & Promising State Practices from CMS/State Discussions. April 2022. https://www.medicaid.gov/resources-for-states/downloads/state-unwinding-best-practices.pdf

52. Cutler-Tran D. Medicaid Agency Workforce Challenges and Unwinding. National Association of Medicaid Directors. March 10, 2023. Accessed April 19, 2026. https://medicaiddirectors.org/resource/medicaid-agency-workforce-challenges-and-unwinding/

53. *Chianne D. v. Harris*. (United States District Court, Middle District of Florida, Jacksonville Division 2026). Accessed January 22, 2026. https://healthlaw.org/wp-content/uploads/2026/01/Chianne-D-FInal-Ruling.pdf

54. Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements — Results from the First Year in Arkansas. *New England Journal of Medicine*. 2019;381(11):1073-1082. doi:10.1056/NEJMsr1901772

55. Musumeci M, Rudowitz R, Lyons B. Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. KFF. December 18, 2018. Accessed January 22, 2026. https://www.kff.org/medicaid/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/

56. Haley JM, Karpman M, Kenney GM, Zuckerman S. *Most Adults in Medicaid-Enrolled Families Are Unaware of Medicaid Renewals Resuming in the Future*. Urban Institute; 2022. https://www.urban.org/research/publication/most-adults-medicaid-enrolled-families-are-unaware-medicaid-renewals-resuming

57. Lopes L, Sparks G, Presiado M, et al. KFF Survey of Medicaid Unwinding. KFF. April 12, 2024. Accessed August 5, 2024. https://www.kff.org/medicaid/poll-finding/kff-survey-of-medicaid-unwinding/

58. McIntyre A, Sommers BD, Aboulafia G, Orav EJ, Epstein AM, Figueroa JF. Experiences with Medicaid unwinding among low-income adults in 4 southern states. *Health Affairs Scholar*. 2025;3(5):qxaf083. doi:10.1093/haschl/qxaf083

59. Hest R. *Tracking the Medicaid Undercount in the 2021 ACS Coverage Data*. State Health Access Data Assistance Center; 2023. https://www.shadac.org/sites/default/files/publications/Medicaid_Undercount_ACS_1.23.pdf

60. Ding D, Sommers BD, Glied SA. Unwinding And The Medicaid Undercount: Millions Enrolled In Medicaid During The Pandemic Thought They Were Uninsured. *Health Affairs*. Published online May 6, 2024. doi:10.1377/hlthaff.2023.01069

61. McIntyre A, Smith RB, Sommers BD. Survey-Reported Coverage in 2019-2022 and Implications for Unwinding Medicaid Continuous Eligibility. *JAMA Health Forum*. 2024;5(4):e240430. doi:10.1001/jamahealthforum.2024.0430

62. Tallevi A. Out of Sight, Out of Mind? Measuring the Relationship between Privatization and Medicaid Self-Reporting. *Journal of Health Politics, Policy and Law*. 2018;43(2):137-183. doi:10.1215/03616878-4303489

63. McClain C. Most Americans don't answer cellphone calls from unknown numbers. Pew Research Center. December 14, 2020. Accessed February 17, 2026. https://www.pewresearch.org/short-reads/2020/12/14/most-americans-dont-answer-cellphone-calls-from-unknown-numbers/

64. Corallo B, Published JT. How Many Medicaid Enrollees Moved In 2020 And What Are The Implications For Unwinding the Public Health Emergency? KFF. March 17, 2022. Accessed August 14, 2025. https://www.kff.org/medicaid/issue-brief/how-many-medicaid-enrollees-moved-in-2020-and-what-are-the-implications-for-unwinding-the-public-health-emergency/

65. Centers for Medicare & Medicaid Services. Use of unwinding-related strategies to support long term improvements (CMCS Informational Bulletin). Published online November 14, 2024.

66. Myerson RM, Espeseth A, Dague L. Navigating Medicaid: Experimental Evidence on Administrative Burden and Coverage Loss. *National Bureau of Economic Research*. Preprint posted online August 2025:34191. doi:10.3386/w34191

67. Wright BJ, Garcia-Alexander G, Weller MA, Baicker K. Low-Cost Behavioral Nudges Increase Medicaid Take-Up Among Eligible Residents Of Oregon. *Health Affairs*. 2017;36(5):838-845. doi:10.1377/hlthaff.2016.1325

68. Staiger B, Li A, Alexander D, Schnell M. Enrollment Brokers Did Not Increase Medicaid Enrollment, 2008–18. *Health Affairs*. 2022;41(9):1333-1341. doi:10.1377/hlthaff.2022.00182

69. Galewitz P. Who Doesn't Text in 2022? Most State Medicaid Programs. *KFF Health News*. April 13, 2022. Accessed January 22, 2026. https://kffhealthnews.org/news/article/state-medicaid-programs-texting-capability-reenrollment-communication/

70. Morales M, Perrow K, O'Connor K. Optimizing SMS Strategies for Outreach to Medicaid and Marketplace Enrollees. State Health & Value Strategies. Accessed January 22, 2026.

https://shvs.org/optimizing-sms-strategies-for-outreach-to-medicaid-and-marketplace-enrollees/

71. Lu Y, Craten KJ, Thompson CT, et al. A Text Message Outreach Intervention to Increase Health Insurance Enrollment for Self-Pay Patients. *Medical Care*. 2025;63(8):600. doi:10.1097/MLR.0000000000002157

72. Percac-Lima S, Singer DE, Cronin PR, Chang Y, Zai AH. Can Text Messages Improve Attendance to Primary Care Appointments in Underserved Populations? *Journal of Health Care for the Poor and Underserved*. 2016;27(4):1709-1725. doi:10.1353/hpu.2016.0157

73. Rodin D, Silow-Carroll S, Cross-Barnet C, Courtot B, Hill I. Strategies to Promote Postpartum Visit Attendance Among Medicaid Participants. *Journal of Women's Health*. 2019;28(9):1246-1253. doi:10.1089/jwh.2018.7568

74. Levine DM, Kakani P, Mehrotra A. Randomized controlled study using text messages to help connect new medicaid beneficiaries to primary care. *npj Digit Med*. 2021;4(1):26. doi:10.1038/s41746-021-00389-5

75. Lopoo LM, Heflin C, Boskovski J. Testing behavioral interventions designed to improve on-time SNAP recertification. *JBPA*. 2020;3(2). doi:10.30636/jbpa.32.183

76. PerryUndem for MACPAC. Beneficiary Experiences with the Medicaid Enrollment and Renewal Processes: Findings from Online Focus Groups with Medicaid Beneficiaries. January 2022. Accessed January 22, 2026. https://www.macpac.gov/wp-content/uploads/2022/01/Beneficiary-Focus-Groups_Communicating-about-Medicaid-Enrollment-and-Renewal-Processes.pdf

77. Domurat R, Menashe I, Yin W. The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment. *American Economic Review*. 2021;111(5):1549-1574. doi:10.1257/aer.20190823

78. Feher A, Menashe I. Using Email And Letters To Reduce Choice Errors Among ACA Marketplace Enrollees: Study examines using email and letters to reduce choice errors among ACA marketplace enrollees. *Health Affairs*. 2021;40(5):812-819. doi:10.1377/hlthaff.2020.02099

79. Myerson R, Tilipman N, Feher A, Li H, Yin W, Menashe I. Personalized Telephone Outreach Increased Health Insurance Take-Up For Hard-To-Reach Populations, But Challenges Remain: Study examines personalized telephone outreach to increase take up of ACA Marketplace enrollment. *Health Affairs*. 2022;41(1):129-137. doi:10.1377/hlthaff.2021.01000

80. Yokum D, Hopkins DJ, Feher A, Safran E, Peck J. Effectiveness of Behaviorally Informed Letters on Health Insurance Marketplace Enrollment: A Randomized Clinical Trial. *JAMA Health Forum*. 2022;3(3):e220034. doi:10.1001/jamahealthforum.2022.0034

81. Ravel K, Ahrary J, Avakian K, Feher A, Menashe I. Effect of Personalized Outreach on Medicaid to Marketplace Coverage Transitions: A Randomized Clinical Trial. *JAMA Health Forum*. 2022;3(10):e223616. doi:10.1001/jamahealthforum.2022.3616

82. Lovchikova M, Feher A, Lian L. Health Plan Switching and Health Care Utilization: A Randomized Clinical Trial. *JAMA Health Forum*. 2024;5(3):e240324. doi:10.1001/jamahealthforum.2024.0324

83. Myerson R, Feher A. Email Nudges Increased Eligibility Verification And Subsidy Receipt In California's ACA Marketplace. *Health Affairs*. 2024;43(9):1235-1243. doi:10.1377/hlthaff.2023.01524

84. Lovchikova M, Wolf E, Menashe I. Smooth Journey: Facilitating Transitions from Medicaid to Marketplace Plans Using Phone Outreach. *Health Affairs Scholar*. Published online August 14, 2025:qxaf163. doi:10.1093/haschl/qxaf163

85. Martin L, Feher A, Schultz W, Safran E, Cohen AK. Interventions to Increase Affordable Care Act Marketplace Enrollment: A Systematic Review and Meta-Analysis. *Population Health Management*. 2024;27(5):327-337. doi:10.1089/pop.2024.0091

86. Dague L, Myerson R. Loss of Medicaid Coverage During the Renewal Process. *JAMA Health Forum*. 2024;5(5):e240839. doi:10.1001/jamahealthforum.2024.0839

87. Rodriguez JO. Native Americans Want To Avoid Past Medicaid Enrollment Snafus as Work Requirements Loom. KFF Health News. August 22, 2025. Accessed April 20, 2026. https://kffhealthnews.org/news/article/native-americans-medicaid-work-requirements-exemptions-montana-nevada/

88. Artiga S, Rudowitz R, Tolbert J. *Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population*. KFF; 2016.

89. Sommers BD, Maylone B, Nguyen KH, Blendon RJ, Epstein AM. The Impact Of State Policies On ACA Applications And Enrollment Among Low-Income Adults In Arkansas, Kentucky, And Texas. *Health Affairs*. 2015;34(6):1010-1018. doi:10.1377/hlthaff.2015.0215

90. Garcia Mosqueira A, Hua LM, Sommers BD. Racial Differences in Awareness of the Affordable Care Act and Application Assistance Among Low-Income Adults in Three Southern States. *INQUIRY*. 2015;52:0046958015609607. doi:10.1177/0046958015609607

91. Ku L, Kwon KN, Jacobs F, Rosenbaum S. Eligibility Assistance Increases Insurance Enrollment Within Community Health Centers But Not At The State Level: Article examines eligibility assistance at community health centers and insurance enrollment. *Health Affairs*. 2025;44(5):606-613. doi:10.1377/hlthaff.2024.01311

92. Karaca-Mandic P, Wilcock A, Baum L, et al. The Volume Of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage. *Health Affairs*. 2017;36(4):747-754. doi:10.1377/hlthaff.2016.1440

93. State Health & Value Strategies. Paid Media Insights for State-Based Marketplace Outreach. September 5, 2023. Accessed January 23, 2026. https://shvs.org/wp-content/uploads/2023/09/Paid-Media-Insights-for-State-Based-Marketplace-Outreach.pdf

94. Stocking G, Kessel P van, Barthel M, Matsa KE, Khuzam M. Many Americans Get News on YouTube, Where News Organizations and Independent Producers Thrive Side by Side. Pew Research Center. September 28, 2020. Accessed April 23, 2026.

https://www.pewresearch.org/journalism/2020/09/28/many-americans-get-news-on-youtube-where-news-organizations-and-independent-producers-thrive-side-by-side/

95. Ercia A, Le N, Wu R. Health insurance enrollment strategies during the Affordable Care Act (ACA): a scoping review on what worked and for whom. *Arch Public Health*. 2021;79(1):129. doi:10.1186/s13690-021-00645-w

96. Chau MM, Ahmed N, Pillai S, Telzak R, Fraser M, Islam NS. Community-Based Organizations as Trusted Messengers in Health. *Hastings Center Report*. 2023;53(S2):S91-S98. doi:10.1002/hast.1529

97. Shen AK, Browne S, Srivastava T, Kornides ML, Tan ASL. Trusted messengers and trusted messages: The role for community-based organizations in promoting COVID-19 and routine immunizations. *Vaccine*. 2023;41(12):1994-2002. doi:10.1016/j.vaccine.2023.02.045

98. Hang K, Sabatoni M, Zemel S, Bates H, Chan-Sawin L. *Medi-Cal Health Navigator Project: Lessons Learned in Medi-Cal Outreach and Enrollment in Rural Northern California*. The Center at Sierra Health Foundation, Transform Health; 2022.

99. Pando C, Tait ME, McGuire CM, et al. Health Insurance Ad Messages Targeted to English- and Spanish-Speaking Populations in a Period of Limited Federal Investment in Marketplace Outreach. *Med Care Res Rev*. 2022;79(6):798-810. doi:10.1177/10775587221101295

100. *Reaching Non-Citizen Communities: Resources to Support State Outreach and Education to Drive Healthcare Enrollment*. State Health & Value Strategies, GMMB; 2022. Accessed January 23, 2026. https://shvs.org/wp-content/uploads/2022/10/Reaching-Non-Citizen-Communities-Resources-to-Support-State-Outreach-and-Education-to-Drive-Healthcare-Enrollment.pdf

101. Silvestri DM, Holland ML, Ross JS. State-Level Population Estimates of Individuals Subject to and Not Meeting Proposed Medicaid Work Requirements. *JAMA Internal Medicine*. 2018;178(11):1552-1555. doi:10.1001/jamainternmed.2018.4196

102. The Ohio Department of Medicaid. *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*. 2017. Accessed January 22, 2026. https://medicaid.ohio.gov/wps/wcm/connect/gov/b0779c0a-5061-45f9-b441-9bf06e2f0070/Group-VIII-Assessment.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_JQGCH4S04P41206HNUKVF31000-b0779c0a-5061-45f9-b441-9bf06e2f0070-nAURfxy

103. Chen S, Staiger B. Medicaid expansion increased income among newly eligible adults. *Health Affairs Scholar*. 2025;3(5):qxaf091. doi:10.1093/haschl/qxaf091

104. *Supplemental Nutrition Assistance Program: More Complete and Accurate Information Needed on Employment and Training Programs*. Government Accountability Office; 2018. Accessed January 22, 2026. https://www.gao.gov/products/gao-19-56

105. Mabli J, Shiferaw L, Rowe G, Schochet P, Monzella K. An Experimental Evaluation of the Impacts of SNAP Employment and Training Pilots on Service Receipt, Labor Market

Outcomes, and SNAP Participation. *Applied Economic Perspectives and Policy*. n/a(n/a). doi:10.1002/aepp.70011

106. Barham T, Cadena BC, Schechter L. Supported Work Leads to Lasting Labor Market Success Among TANF Recipients. Published online December 2025. https://docs.iza.org/dp18342.pdf

107. Card D, Kluve J, Weber A. What Works? A Meta Analysis of Recent Active Labor Market Program Evaluations. *Journal of the European Economic Association*. 2018;16(3):894-931. doi:10.1093/jeea/jvx028